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State of Washington
Department of Health
DIVISION OF PUBLIC HEALTH LABORATORIES
1610 N.E. 150th St. K17-9 Shoreline Washington 98155-9701

REQUEST FOR ANTIBODIES TO HIV

10

COUNTY CITY

DATE SPECIMEN OBTAINED
MONTH DAY YEAR
/ /

DATE RECEIVED | REASON | SEX 1 ☐ M 2 ☐ F | AGE | TYPE | SOURCE

RACE
☐ 1 ASIAN
☐ 2 BLACK
☐ 3 CAUCASIAN
☐ 4 HISPANIC
☐ 5 Native American
☐ 6 OTHER

MARITAL STATUS
☐ 1 SINGLE
☐ 2 MARRIED
☐ 3 DIVORCED

PATIENT'S IDENTIFICATION NAME OPTIONAL (LAST) (FIRST) (INITIAL)

ADDRESS CITY ZIP CODE

MAIL RESULTS TO : >

ADDRESS: >

CITY: > ZIP CODE

PHONE NUMBER
( )

TYPE OF TEST REQUESTED:
☐ ELISA
☐ WESTERN BLOT
☐ OTHER

STATUS OF PATIENT: (CHECK ALL THAT APPLY SINCE 1977)

1 ☐ HOMOSEXUAL
2 ☐ BISEXUAL
3 ☐ PROSTITUTE
4 ☐ CLIENT OF PROSTITUTE
5 ☐ SEX CONTACT OF PERSON AT RISK
6 ☐ FREQUENT DIFFERENT HETEROSEXUAL CONTACTS (>10/YEAR)
7 ☐ HISTORY OF IV DRUG ABUSE
8 ☐ CHILD OF PARENT AT RISK
9 ☐ HEMOPHILIAC
10 ☐ HISTORY OF BLOOD TRANSFUSION
11 ☐ POSITIVE BLOOD DONOR
12 ☐ POSITIVE PLASMA DONOR
13 ☐ NO RISK FACTOR PRESENT
14 ☐ INFORMATION WITHHELD

HAS THE PATIENT BEEN COUNSELED?_____

HAS AN HIV ELISA BEEN PERFORMED ELSEWHERE ON THIS SPECIMEN?
BRAND OF ELISA _____ RESULT

REASON FOR SPECIMEN: ☐ SCREENING ☐ REFERENCE
☐ SYMPTOM EVALUATION (ARC)

IF REFERENCE, GIVE TEST RESULTS:_____BRAND OF ELISA_____

HAS A PREVIOUS SPECIMEN ON THIS PATIENT BEEN TESTED AT THE STATE LAB?
☐ YES ☐ NO

IF YES, GIVE:

STATE LAB NUMBER: 10 _____

DATE SPECIMEN OBTAINED: _____ / _____ / _____

DO NOT WRITE BELOW THIS LINE

LABORATORY REPORT

TYPE OF TEST	SUPPLEMENTAL TEST							
	NEG	POS	IND		NEG	POS	IND	
ELISA								
WESTERN BLOT								

COMMENTS:

TESTED BY	UNIT HEAD
DATE OF FINAL REPORT	

DOH 303-001 (Rev. 4/97) * * f